Assembly Bill No. 1124

CHAPTER 8

An act to amend Section 14105.22 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor March 28, 2014. Filed with Secretary of State March 28, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1124, Muratsuchi. Medi-Cal: reimbursement rates.

Existing law states the intent of the Legislature that the State Department of Health Care Services develop Medi-Cal reimbursement rates for clinical laboratory or laboratory services in accordance with specified criteria. Existing law exempts from compliance with a specified regulation laboratory providers reimbursed pursuant to any payment reductions implemented pursuant to these provisions for 21 months following the date of implementation of this reduction, and requires the department to adopt emergency regulations by July 1, 2014.

This bill would instead exempt these laboratory providers from compliance with the specified regulation until July 1, 2015, and would require the department to adopt emergency regulations by June 30, 2016.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 14105.22 of the Welfare and Institutions Code is amended to read:

14105.22. (a) (1) Reimbursement for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, shall not exceed 80 percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(2) This subdivision shall be implemented only until the new rate methodology under subdivision (b) is approved by the federal Centers for Medicare and Medicaid Services (CMS).

(b) (1) It is the intent of the Legislature that the department develop reimbursement rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for clinical laboratory or laboratory services. Development of these rates will enable

the department to reimburse clinical laboratory or laboratory service providers in compliance with state and federal law.

(2) (A) The provisions of Section 51501(a) of Title 22 of the California Code of Regulations shall not apply to laboratory providers reimbursed under the new rate methodology developed for clinical laboratories or laboratory services pursuant to this subdivision.

(B) In addition to subparagraph (A), laboratory providers reimbursed under any payment reductions implemented pursuant to this section shall not be subject to the provisions of Section 51501(a) of Title 22 of the California Code of Regulations until July 1, 2015.

(3) Reimbursement to providers for clinical laboratory or laboratory services shall not exceed the lowest of the following:

(A) The amount billed.

(B) The charge to the general public.

(C) Eighty percent of the lowest maximum allowance established by the federal Medicare Program for the same or similar services.

(D) A reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying for similar clinical laboratory or laboratory services.

(4) (A) In addition to the payment reductions implemented pursuant to Section 14105.192, payments shall be reduced by up to 10 percent for clinical laboratory or laboratory services, as defined in Section 51137.2 of Title 22 of the California Code of Regulations, for dates of service on and after July 1, 2012. The payment reductions pursuant to this paragraph shall continue until the new rate methodology under this subdivision has been approved by CMS.

(B) Notwithstanding subparagraph (A), the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to subdivision (aa) of Section 14132 shall be exempt from the payment reduction specified in this section.

(5) (A) For purposes of establishing reimbursement rates for clinical laboratory or laboratory services based on the lowest amounts other payers are paying providers for similar clinical laboratory or laboratory services, laboratory service providers shall submit data reports within 11 months of the date the act that added this paragraph becomes effective and annually thereafter. The data initially provided shall be for the 2011 calendar year, and for each subsequent year, shall be based on the previous calendar year and shall specify the provider's lowest amounts other payers are paying, including other state Medicaid programs and private insurance, minus discounts and rebates. The specific data required for submission under this subparagraph and the format for the data submission shall be determined and specified by the department after receiving stakeholder input pursuant to paragraph (7).

(B) The data submitted pursuant to subparagraph (A) may be used to determine reimbursement rates by procedure code based on an average of the lowest amount other payers are paying providers for similar clinical laboratory or laboratory services, excluding significant deviations of cost

or volume factors and with consideration to geographical areas. The department shall have the discretion to determine the specific methodology and factors used in the development of the lowest average amount under this subparagraph to ensure compliance with federal Medicaid law and regulations as specified in paragraph (10).

(C) For purposes of subparagraph (B), the department may contract with a vendor for the purposes of collecting payment data reports from clinical laboratories, analyzing payment information, and calculating a proposed rate.

(D) The proposed rates calculated by the vendor described in subparagraph (C) may be used in determining the lowest reimbursement rate for clinical laboratories or laboratory services in accordance with paragraph (3).

(E) Data reports submitted to the department shall be certified by the provider's certified financial officer or an authorized individual.

(F) Clinical laboratory providers that fail to submit data reports within 30 working days from the time requested by the department shall be subject to the suspension provisions of subdivisions (a) and (c) of Section 14123.

(6) Data reports provided to the department pursuant to this section shall be confidential and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(7) The department shall seek stakeholder input on the ratesetting methodology.

(8) (A) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking any further regulatory action, implement, interpret, or make specific this section by means of provider bulletins or similar instructions until regulations are adopted. It is the intent of the Legislature that the department have temporary authority as necessary to implement program changes until completion of the regulatory process.

(B) The department shall adopt emergency regulations no later than June 30, 2016. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted pursuant to this section. The initial adoption of emergency regulations implementing the amendments to this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law.

(C) The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(9) To the extent that the director determines that the new methodology or payment reductions are not consistent with the requirements of Section 1396a(a)(30)(A) of Title 42 of the United States Code, the department may revert to the methodology under subdivision (a) to ensure access to care is not compromised.

(10) (A) The department shall implement this section in a manner that is consistent with federal Medicaid law and regulations. The director shall seek any necessary federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval is obtained.

(B) In determining whether federal financial participation is available, the director shall determine whether the rates and payments comply with applicable federal Medicaid requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(C) To the extent that the director determines that the rates and payments do not comply with applicable federal Medicaid requirements or that federal financial participation is not available with respect to any reimbursement rate, the director retains the discretion not to implement that rate or payment and may revise the rate or payment as necessary to comply with federal Medicaid requirements. The department shall notify the Joint Legislative Budget Committee 10 days prior to revising the rate or payment to comply with federal Medicaid requirements.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that the State Department of Health Care Services can establish a new pricing methodology by the statutory deadline, it is necessary that this act take effect immediately.

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